# PROGRESS

## IN THIS ISSUE




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AWARENESS · KNOWLEDGE · UNDERSTANDING

PREVENTION


THE ALCOHOLISM FOUNDATION OF ALBERTA

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**PROGRESS** is published regularly by The Alcoholism Foundation of Alberta in order that a more comprehensive knowledge, greater understanding, and more objective viewpoint of the illness alcoholism be provided the people of this Province.

**PROGRESS** contains authoritative and pertinent material selected, as well as initiated to be of interest to those members of professions concerned with the treatment and rehabilitation of the Alcoholic, and to those lay readers who desire to understand more fully the complexity of the illness, Alcoholism.

All material in **PROGRESS** is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

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PROGRESS

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One of the nicest things about Christmas
and the New Year
is that it makes us all take time
to remember Old and New Friends.

It also affords us the opportunity to express
our Gratitude to all of you who have made
it possible for us to do our job.

We feel that such Progress as we may make
is due to the Co-operation and continuing
sincere Support we receive from so many others.

May we extend to you our

Season's Greetings

and

All Best Wishes for the New Year

J. George Strachan and Staff
The Alcoholism Foundation
of Alberta

# Research Needs in Alberta

*by Dr. E. M. Jellinek*
*Chief Consultant and Director of Professional Training*

We hear and read often about the alcohol problem and the problem of alcoholism. Some of us wonder whether these problems actually exist, and, if they do exist, whether they are of any important magnitude. Quite a few of us are inclined to believe that both these problems have been invented by the Temperance Societies who are quite emphatic about the significance and magnitude of the damage arising from the use of alcoholic beverages. That the vested interests on the other hand would like to regard these problems as rather minor ones, or even negate their existence, is quite natural.

But you must consider the fact that hundreds of outstanding scientists in the medical, biological and social sciences have given much of their time and energy to the study of these questions. And that is true, not only in Canada and the United States, but also for the majority of European and, more recently, South American countries. Australia and New Zealand, too, are now engaged in such work.

I could give you perhaps some idea of the magnitude of the problem involved in terms of the estimates of the number of alcoholics, but I am somewhat loath to do that, as these estimates emanate from a formula for which I, myself, am responsible and in which I place less faith than many of my scientific colleagues. Generally, it has been said by statisticians that my estimation formula tends to under-estimate rather than over-estimate the number of alcoholics. I am really not concerned with this because the estimates go into millions and even if I should have made an error of 25% either way, it wouldn't matter much. Even with a minus 25% error the number would still be one which would compel public health authorities and civically-minded persons to give rather serious consideration to these problems. This consideration is evidenced in the growth of public and private alcoholism programs.

**International Concern**

In Canada, six provinces have provided legislation on the public care of alcoholics and on the prevention of alcoholism, and five have, at present, active programs on the treatment of alcoholics, education and research. Among these, of course, is Alberta, whose Foundation has vigorous centres in Edmonton and Calgary, both of which are expanding and becoming more and more effective. In the United States, 39 state governments have enacted similar legislation.

I may add that some of the European countries had adopted such legislation and activities long before

*Dr. E. M. Jellinek*

*We are pleased to announce the appointment of Dr. Jellinek to the permanent staff of the Foundation, as Chief Consultant and Director of Professional Training. Dr. Jellinek has also been appointed Honorary Clinical Professor in Psychiatry by the University of Alberta, where he will be lecturing on Alcohol and Alcoholism to Fourth Year Medical Students. Dr. Jellinek will continue as advisor and consultant to the Alcoholism Research Foundation of Ontario.*

us; others, including South American countries, Australia and New Zealand, have followed our example and patterned their activities upon ours.

The magnitude and serious nature of these problems is furthermore shown by the fact that the American Medical Association has created an Alcoholism Committee, which, in turn, has sparked the formation of alcoholism committees in a large number of state medical societies. There is an increasing awareness of this problem and recognition of the need to do something about it in the United States National Institute of Mental Health. The largest public health body, the World Health Organization, have incorporated in their program the control of alcoholism, and have greatly influenced the formation of new alcoholism programs and the reorientation of out-of-date programs in many countries.

Private initiative, particularly in the United States, has created voluntary alcoholism programs of which now more than fifty exist, and, as a matter of fact, some of these voluntary organizations, such as the Yale University's Center on Alcoholism, and the National Council on Alcoholism, by far ante-date the State and Provincial activities. And, of course, we must acknowledge the contribution made by the fellowship of Alcoholics Anonymous which began about 25 years ago.

**Industrial Programs**

It should also be noted that a number of industrial enterprises in Canada, and particularly in the United States, have created alcoholism services within their own organizations, or have fostered outside facilities for the treatment and rehabilitation of alcoholic employees. They found that the money so invested resulted in great savings in comparison to the old method of firing such people and hiring new ones, who had to be trained for many months or years until they had acquired the know-how of the discharged persons.

That so many government and civic bodies should have given thought and the financial means to these activities, of course indicates that the problem has been recognized as a rather serious one.

In characterizing the magnitude of these problems, I may further call to your attention that we have today an alcohol and alcoholism literature which contains more than

50,000 titles and which range over the medical, biological, psychological, social and economic aspects of this knotty subject.

I will freely admit than an overwhelming percentage of the 50,000 papers and books could have just as well remained unwritten, but in our present times about 300 to 500 truly scientific papers are produced every year and are largely contained in four specialized journals — one American, one British, one French and one Swedish — and of these 300 to 500 papers about half are highly relevant to the matter under consideration. If so much thought and time are devoted to this subject by governments, intergovernmental organizations, medical and other professional groups, and voluntary societies, there can be little doubt that this question is of prime importance.

**Expenditures Inadequate**

We people of the North American continent, whether we are Canadians or from south of the border, are accustomed to clamor for research and more research when we are confronted with grievous social, economic, or medical problems.

While, as I have said before, our activities relating to treatment and rehabilitation of alcoholics have reached a relatively high level, the public demand for research has not been exactly clamorous. Expenditure on research in this field is far from that which we are accustomed to devote to other problems of similar or even much smaller magnitude.

The large Foundations for the subsidy of human welfare, science and education, and the pocket-books of private donors are just beginning to open up for the support of research on alcoholism, and even these beginnings, while they are promising, are at present somewhat timid.

We research men who have tackled these problems of alcohol and alcoholism with the same objectivity which we apply to the investigation of, for instance, the life of kangaroos or disease-resistant varieties of wheat, have been handicapped greatly by the public's attitudes inherited from prohibition times, and the wrangling between the 'wets' and the 'drys'. The great Foundations have just come to realize that research in these fields by no means needs to be involved in emotional encumbrances. The general public is quite a bit slower in recognizing this.

**Two Research Categories**

What ARE our research needs? First of all I must make a rigorous distinction between two categories of research. The first one concerns the effects of alcohol on various organs and their functions, on various biochemical substances in the blood and other body tissues, and on a large variety of psychological functions.

The other category relates to that medical condition or illness which we call alcoholism. There are, of course, inter-relations between these two categories of research, but nevertheless a certain separation is required.

The research on the effects of alcohol is at least 100 years old. The incentives for such investigations have come from various sources, which would be interesting to mention, but would lead me into a too lengthy discussion. I should like to refer only to the fact that with the growth of industrialization quite a bit of incentive for research on the effects of alcohol has come from industrial management, who had become a bit leery about the old belief that alcoholic beverages overcome fatigue, restore or increase energy and efficiency, and generally had health-giving properties.

In the field of alcohol effects, we have accumulated a large, though still inadequate, fund of knowledge.

On the other hand, research on the illness termed alcoholism has a brief history. For a long time, it was regarded as quite legitimate to explore the pharmacological effects of alcohol, but disreputable to do research on alcoholism which, not so long ago, was referred to as habitual drunkenness. Today we recognize that this is our greatest problem related to alcohol.

Truly relevant research in this latter field has been carried out only in the past 25 or 30 years and the most important ones only in the past 15 years. We have today very good leads and very good working hypotheses on the origins of alcoholism, but they are still hypotheses. Of course, a knowledge of the factors operating in the genesis of alcoholism are prerequisite to the effective treatment as well as to the prevention of the illness.

There has developed a much greater understanding of the psychiatric and psychological aspects, and there is slowly developing more of an understanding of possible contributing physiological, or to be more exact, physio - pathological factors. These experimental researches will be elaborated in the great research laboratories of large institutions and they are seldom appropriate for the research worker who works outside the framework of great universities with their extraordinary laboratory facilities and equipment. Furthermore, any physiological or biochemical findings which have come from highly qualified research workers at the University of Sidney, Australia, or at the University of Chile, or at McGill, or Harvard are, by and large, equally valid for any nation.

**The Local Picture**

In Alberta, we need not be too much concerned about fostering pharmacological research on alcoholism, but by no means do I wish to imply that if anybody in Alberta has a highly original idea on the matter, he should leave it to McGill or Yale On the contrary, he should, in that case, be encouraged and properly subsidized locally.

On the other hand, sociological research is quite a different matter, and socio-cultural research is no less important than psychiatric and pharmacological investigation. It is quite a different matter, because what may be true sociologically in Manitoba may be only half true in Alberta: and sociological research perhaps has more to do with the prevention of the illness than psychological and pharmacological knowledge.

I have had the opportunity to explore certain attitudes toward drinking and certain drinking customs and drinking patterns in various European and Latin American countries on behalf of the World Health Organization. In those societies, I found that many of the differences in the incidence of alcoholism and of other alcohol connected damage may be attributed largely to differences in socio-cultural attitudes.

Our preventive education is carried out with much zeal, but a proper basis for preventive education may be said to be lacking. The necessary basis we may obtain from sociological research, and this is the field on which the Alberta Foundation is placing, at present, the main weight, and which merits the consideration and support of the citizens of Alberta.

*(The above is taken from a recent address by Dr. Jellinek to the Men's Canadian Club, Edmonton.)*

# Counselling the Alcoholic

*by A. W. Fraser*
*Associate Director, Treatment Services.*

In any counselling situation, regardless of the extent of the help or therapy that is being planned, little will be accomplished unless a good relationship is established between the counsellor and the patient. The development of an effective counselling relationship is dependent almost totally on the counseller's attitude towards the patient. By his attitude the counsellor must convey that, regardless of the nature of the problem or type of behavior involved, he respects the patient as a person, and feels he is worthy of attention, that he is concerned about the patient's difficulties and is willing and able to help him resolve them.

With many types of patients, the counsellor can depend on having several interviews in which to demonstrate his acceptance of the patient, in which to **build** a relationship. With the active alcoholic, it is often make or break in the first interview. The alcoholic is supersensitive to indications of rejection. He has very low tolerance for disapproval and for frustration of his immediate needs. If he senses any degree of disapproval or lack of acceptance in the counsellor's attitude, it is highly unlikely that anything the counsellor says will reach him, or that he will return for another interview. Thus, more so than with most types of patients, the initial interview with the alcoholic is of prime importance in establishing a working relationship and in bringing him back for further interviews.

The success of the initial interview is to a large extent dependent on the completeness of the counsellor's acceptance of alcoholism as an illness, and, more important, of the alcoholic as a sick but worthwhile person.

Due to the accomplishments of Alcoholics Anonymous, to the growing number of organizations like the Foundation, and to the increasing amount of public education on the subject, there is a growing intellectual acceptance by the public of alcoholism as a treatable illness. Among those working in the field of social service, this acceptance has become quite general. However, accepting the intellectual concept of alcoholism as an illness is one thing; it is quite another matter to accept fully the alcoholic as a sick person, worth your time and effort, when you are directly confronted with him or when you hear of his behavior from the wife or a relative.

Much of the alcoholic's behavior, if assessed purely by social, ethical or moral standards is unacceptable and unworthy. The alcoholic's personal attitude and conduct in the counselling situation, his resistance to treatment, his apparent refusal to face facts, his self-centred approach to any and all problems, if not well understood as a part of his illness, can quickly be frustrating and discouraging to those trying to help him.

However, if the counsellor has an understanding of some of the psychological factors involved, an understanding of the alcoholic's emo-

tional condition at the time he presents himself for help, then the counsellor will have much less difficulty in accepting him and approaching him in such a way that a workable relationship will develop.

I am going to deal briefly with a number of these factors, but before doing so I would like to reinforce two important points about the nature of alcoholism.

1. Counsellors who are dealing with alcoholics should have no doubt whatsoever about the absolute necessity for complete, continuous sobriety in any case of alcoholism. Once a person becomes alcoholic, he has as little control over his reaction to alcohol as the person who has become diabetic can control his reaction to sugar. This reaction is entirely beyond the control of conscious will.

2. The alcoholic can never again be a moderate or controlled drinker. It does not matter how long he has stayed completely sober; it does not matter how many of his social and emotional problems have been resolved during this period of sobriety, if he tries again to be a moderate drinker it will only be a matter of months probably before he is again drinking in his old alcoholic pattern.

The following features of the emotional condition of the alcoholic when he presents himself for treatment are not unique to the alcoholic, but this particular cluster of features or symptoms, are more pronouncedly expressed in this type of patient, and thus warrant particular consideration by those who hope to approach him successfully.

1. The alcoholic has not presented himself for treatment because he wants to be there. He is there because he has been forced into it by someone or some thing (a wife, employer, or some crisis that has arisen as a result of his drinking). He is the victim of strong conflicting impulses. On the one hand, he wants help and support in overcoming his problems; on the other hand, he wants to maintain his independence and his freedom to do as he wants, including more drinking.

Of these conflicting impulses, the desire to seek help is temporarily in ascendency. However, it may not take much to tip the balance the other way. He should, therefore, be granted an interview as quickly as possible, otherwise the added frustration of waiting, of not receiving immediate attention to his demand for help may cause him to withdraw from treatment, perhaps physically by walking out, more likely emotionally by arousing such resistance that the counsellor cannot reach him.

The time will come when you can have him wait his turn, when he can tolerate the fact that there are other demands on the counsellor's time, and other patients whose needs are as urgent as his own, but to expect this of him immediately on his first appearance is a failure on the counsellor's part either to understand, or to accept, a feature of this person's illness.

Another result of these conflicting impulses to seek and to reject help is that the patient will ask for, often demand, help on his own terms. Even though it may not be advisable to accede to all of his demands, pehaps to none of them, yet it is essential that regardless of the reasonableness or unreasonableness of these demands, they be given an impartial hearing by the counsellor, that the alcoholic be given the opportunity to express his demands, and that he receive a considered explanation of how some of these demands

will be met, or why some of them cannot be.

2. A second factor of which counsellors must be aware is that regardless of how the alcoholic talks, his self-esteem is at a very low ebb. He may demonstrate this by being submissive, remorseful and self-depreciating, or he may defend against reduced feelings of self-esteem by being arrogant and demanding, then again, he may alternate between these two. However, regardless of the patient's initial approach, if he receives courteous attention, if he is listened to with respect, it demonstrates to him that the counsellor feels he is **worth** listening to, worth the time and the trouble that he is causing, and thus helps to restore his feelings of personal worth.

3. The alcoholic has strong ambivalence towards authority and so has difficulty in dealing with any type of authority figure. He may fluctuate between submissiveness and being compliant, to rebelliousness and being negativistic. He often is extremely touchy about being shoved around. He is sensitive about any flavor of officiousness or lecturing. Another way of expressing this is to say that the active alcoholic is a very dependent person who resents and over-reacts against his own extreme dependency. When he is sick or in serious touble, he will want the counsellor to take over completely, to do everything for him; but a short time later when he is feeling somewhat better, he will want to do everything for himself and will start denying any need for help. He will break appointments, fail to turn up for interviews, and often he will express resentment at what he feels is the counsellor's attempt to take over or to interfere with his affairs. If the counsellor anticipates this he will be undisturbed when it happens. The counsellor who is unprepared for this type of reaction on the part of the alcoholic may feel rejected and unappreciated and therefore react with hostility towards his patient.

4. One of the most difficult things for a counsellor to understand and to accept when dealing with the alcoholic is the patient's inability to recognize that he has a serious drinking problem, regardless of how obvious his alcoholism may be to others. Despite what the counsellor may regard as undeniable evidence of alcoholism, the patient will persist in his claim that his drinking has little if any connection with his problem. He may recognize that he drinks a bit too much at times, but will claim that this is not really too important, and that he can take it or leave it alone. Often this is regarded as deliberate lying and misrepresentation by the alcoholic, but such is not the case. The alcoholic is truly unable to recognize that his drinking is out of control. He is protected from this by the emotional defence processes of rationalization, projection and denial, and so he indignantly contends that his drinking has little to do with his real difficulties; that his real problems are caused by his demanding wife, or by his unappreciative boss, by the terrible job he has, by the many responsibilities which weigh upon him. Everything or anything can be wrong, can be to blame for his many difficulties, **except** his drinking.

Unless the counsellor is fully aware that the basic purpose of this denial, of the all-too-transparent rationalizations and projections, is to protect the last shaky remnants of self-esteem, he may directly attack the alcoholic's stated reasons and attempt to break them down and get

him to recognize the situation as it really is. This will be far too threatening to the patient and he will back away from the situation and will reject the counsellor post-haste.

Recognition of his alcoholism is a double-barrelled threat to the alcoholic. Firstly, there is the stigma attached to it — the fact that it is commonly regarded as an indication of a shameful weakness, of personal worthlessness. Also, if he admits his alcoholism, he will have to accept responsibility for all the hardships, the difficulties, the pain to his loved ones, that his drinking has caused, and this threatens further intense feelings of shame and worthlessness.

Secondly, it would mean accepting the responsibility of giving up drinking entirely. Because of the strong dependency that the alcoholic has developed on drinking, the idea of life without drinking is a truly terrifying thought to him. Only after the counsellor has conveyed to the patient his own conviction that alcoholism is an illness, can the patient start to regard it as such. When he starts to do this, then recognition of his alcoholism will be much less threatening to his self-esteem, and the emotional defences against such recognition will be weakened. When the alcoholic is showing some ability to recognize and accept his own alcoholism, it will be time enough to have him consider giving up drinking completely.

Finally, I would like to point out that apart from the specific difficulty of having to establish almost immediate rapport with him, the alcoholic patient is no more difficult to work with than most other types of patients, and that his prognosis, once treatment has started, is just as good and perhaps even better than with others.

# New International Commission on Alcoholism

A new United States-Canadian Commission on Alcoholism was announced by Dr. Authur S. Flemming, United States Secretary of Health, Education and Welfare, on November 21st.

This new Commission, financed by a million dollar grant from the United States Government, will review the state of knowledge about the field of alcoholism, investigate treatment, education and research accomplishments, and try to determine what should be done over the next twenty years.

The work of the Commission will extend over a five year period, and involve some of the best scientific, administrative and organizational brains in both countries.

The task of the Commission has been stated in the widest possible terms, so that no important aspect of anything that contributes to alcoholism or problem drinking will be neglected. Everything from the existing institutions for dealing with alcoholics to the lobbies of all kinds surrounding the use of alcohol, to the temperance movement, to sales programs, to law enforcement methods and courts, and to health, welfare and educational agencies will be looked at systematically.

Mr. J. George Strachan commented, "The creation of the new Commission will do much to encourage further interest and financial support from our governments, business and industry, and major philanthropic organizations."

# The Problem of Teen Age Drinking

*Reprinted from, 'News', Cleveland Center on Alcoholism.*

During recent years there has been growing alarm about drinking among adolescents. One sometimes gets the impression that many teen-age parties are drunken brawls, that sharp rises in delinquency and unwed motherhood can be traced to the guzzling of alcohol, and that high school students are forever sneaking off to rest rooms for a quickie.

The evidence does not support these notions despite the fact that teen-age drinking is probably increasing. Michigan sociologist, Christopher Sower, for example, found that one-third of 2247 junior and senior high school students drank occasionally. In Nassau County, New York, it was discovered that 70% of 1000 youngsters questioned had sampled alcoholic beverages by the time they were fourteen and this increased to 90% at the age of sixteen. Similar conditions have been found elsewhere.

The explosive but futile reactions to these data have tended to blind parents, teachers and law-enforcement officials to the fact that while teen-agers are drinking in ever-increasing numbers, the consequences may not be as disastrous as the statistics imply. A lot of teen-agers may drink but most of them don't drink much.

One fact is of paramount importance. The drinking of alcoholic beverages is an established custom in our society and indulged by at least two-thirds of the adult population. Children growing up in this society are likely to accept the pattern.

Sound education rather than prohibition is the goal. In schools and homes we teach teen-agers all we know about the hazards of misusing the privilege of driving and it would appear that the same approach is valid for drinking. This does not mean the use of scare techniques which are frequently self-defeating. There is little point, for example, to the warning that anyone who drinks can become alcoholic. It is true, of course, but it is equally true most people who drink do not become alcoholic.

The attitudes that are created as the result of education will play a vital role in the teen-ager's approach to drinking. It makes a difference whether the boy approaching maturity thinks he has to drink 'to be a man' or if he can view drinking as a custom he can accept or reject in moderation according to his own choice. There is a difference between the college girl who drinks because it is a deliciously wicked thing to do, and the one who can accept a cocktail as the adult she is striving to be. And above all, education in this area is never education to drink but education about alcohol with the decision to drink or not drink always a matter for individual judgment.

# Alcoholics Anonymous:
## "The Twelve Steps."

*This is Number Two in a series of articles relative to the fellowship of Alcoholics Anonymous as prepared and released by General Service Headquarters of Alcoholics Anonymous.*

The core of the Alcoholics Anonymous program, through which thousands of once hopeless problem drinkers have achieved sobriety, is a series of twelve suggested 'Steps' that sums up the experience of the early members even before the Fellowship had a name.

First published in Alcoholics Anonymous, the A.A. book of experience, in 1939, five years after the movement got under way, the Twelve Steps constitute a suggested program rather than a fixed creed.

This in itself is typical of the society which now has an estimated 250,000 members in approximately 7,500 local groups in over 70 countries. For, as one old-timer has remarked: "In A.A., we never try to tell anyone what to do; all we can do is show them how we ourselves got sober and stayed sober."

Since they are essentially a formula for changing a person's way of thinking and living, how do most newcomers to A.A. react to these Twelve Steps?

"They react in either one of two ways," members with relatively long periods of sobriety assert. "Newcomers either accept the Steps — lock, stock and barrel, without question — or they have serious reservations about them that have to be resolved before the program makes sense."

What kind of reservations?

"For one thing, a number of the Steps refer to God. The newcomer may want sobriety and he may come from a family background that emphasized spiritual values but, after years of drinking, he may be pretty cynical about any reference of that type."

"Once the newcomer appreciates that A.A. is not a religious program in the denominational sense he can begin to understand the broad concept of God that runs all through the Twelve Steps. It is a purely personal concept. It is always 'God as we understand Him' or 'a Power greater than ourselves'. Most people respect some form of power greater than themselves. Most of us call that Power, God. The alcoholic who can't stop drinking is up against a power he can't control, a power greater than himself. A. A. merely suggests that he substitute another Power, whatever he may choose to call it, and switch his dependence

from alcohol to his newly - found concept."

These are the Twelve Steps, as they appear in A.A. literature:

1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God **as we understood Him.**
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contract with God **as we understood Him,** praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and practice these principles in all our affairs.

Most A.A. members are quick to point out that the Twelve Steps contain nothing that is really new. All the principles underlying the Steps can be found in the teachings of the great spiritual leaders. The effectiveness of the A.A. program, members suggest, depends upon the unique ability of one alcoholic to identify himself with another.

It is generally agreed that full and unreserved acceptance of the first Step — "We admitted we were powerless over alcohol" — is crucial for the alcoholic who has expressed a desire to stop drinking. He must be absolutely honest in that desire and it must be based on the realization that he cannot control alcohol, that it has him licked. If the newcomer clings to any lingering doubts about the possibility of being able to control his drinking in the future, the A.A. program is not likely to work permanently for him, old-timers remark.

In some cases individuals have achieved and maintained sobriety solely through understanding and accepting the total importance of the first Step. But the record shows that those members who make a serious attempt to 'work' all the Steps have a better chance of keeping their sobriety.

Personal interpretations of the Twelve Steps are common in A.A. where no one speaks for the society as a whole, or even for the local community group. Each member is free at all times to express his own opinion on matters related to the recovery program.

The opinion of one member pretty well sums up the significance of the Twelve Steps to A.A.:

"You can accept them from the first second you see them, or you can try to analyze them and interpret them all you want to; if you're honest in wanting to stop drinking, it all boils down to the same thing: they work!"

Few A.A.'s, recalling the problems and sufferings of their drinking days, could ask for much more.

The Alcoholism Foundation of Alberta is a Private Agency, incorporated under the Societies Act in 1951, financed by provincial and municipal grants, corporate and private contributions.

The services of The Foundation are available to individuals or groups desiring information or assistance with problem drinking situations. Patient counselling, medical, educational and research services are provided through the two Centres located in Edmonton and Calgary.

The Foundation recognizes alcoholism as a treatable illness, a serious public health problem and, therefore, a public responsibility.

The Foundation's approach is professional and at all times avoids controversy.

Through its three-point program of Treatment, Education and Research, The Foundation is directing its efforts toward a beginning solution of this major public health and social problem, the ultimate of which is eventual prevention.

J. George Strachan
Executive Director

**CENTRES AND CLINICS**

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## Foundation Services

- ADVISORY SERVICES: Professional advice and assistance on the problems of alcoholism.
- AUDIO-VISUAL AIDS: Films, tapes, records and displays are available on loan.
- CONFERENCES AND SEMINARS: On alcohol studies to create a better understanding of the problems of alcoholism and methods of dealing with those problems.
- INDUSTRIAL WORKSHOPS: For the education of management, supervisory staffs and general employees in Alberta industry.
- ORIENTATION PROGRAMS: For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers and other groups.
- PUBLICATIONS: Progress, News Review, Foundation Reporter, Digest on Alcohol Studies and Original Brochures and Pamphlets.
- REFERENCE LIBRARY: Books, pamphlets and publications by authorities in the field of alcoholism.
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